Date: July 23, 2002

To: Medicare+Choice Organizations and Demonstration Projects required to utilize the Medicare Standardized Summary of Benefits

From: Gary A. Bailey, Director, Health Plan Benefits Group, Centers for Medicare and Medicaid Services

Subject: 2003 Standardized Summary of Benefits (SB) Instructions

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Requirements for use of the standardized SB apply to all Medicare+Choice Organizations (M+COs) and certain managed care demonstration projects. M+COs and the demonstration projects are also encouraged to post questions through the Internet to: sb2003@cms.hhs.gov. The Centers for Medicare and Medicaid Services (CMS) will post answers to these questions on the web site at regular intervals.

For purposes of simplicity, the term M+CO contractor or organization is used throughout this document. The term "plan" refers to the benefit package offered by an M+CO contractor.

Background

The SB is the primary pre-enrollment document used by M+COs to inform potential and current members of the plan benefit packages offered by M+COs. Similarly, Medicare beneficiaries have indicated the SB is the single most important document produced by the M+COs that assists the beneficiary in making a health care selection.

The Standardized Summary of Benefits was developed jointly between the Medicare Managed Care Industry and Beneficiary Groups to establish consistency and standardization in benefit descriptions that are provided to Medicare beneficiaries. M+COs participating in the M+C program provide a side-by-side comparison of plan benefits to the original Medicare fee-for-service benefit package so the potential member can view the benefit enhancements the M+CO offers beyond the Original Medicare program.

The standardized SB is a stand-alone marketing document that is generated from the Plan Benefit Package (PBP). The SB contains the following sections:

(1) beneficiary information section, which informs potential members of important aspects of participating in the M+C program (two pages, standard format, and text);

(2) benefit comparison matrix (approximately 10 pages, standard form, and text); and

(3) M+CO special features sections (4 pages of promotional text and graphics; free format, and text).

The SB is a "summary" document and therefore, not intended to include benefit information in the same detail as the Evidence of Coverage. The SB and Medicare Health Plan Compare will contain the same information in the same format for CY 2003.

For CY 2003, the PBP will include several enhancements from CY 2002. Several changes suggested by the managed care industry, Medicare beneficiaries, and other interested parties have been incorporated. These changes will allow M+COs greater flexibility to describe their benefit packages in a more accurate fashion. M+COs should generate Sections 1 and 2 of the SB from their completed PBP, download the sections into the appropriate publishing software, and combine them with Section 3 to form a complete SB. M+COs may make **only** the necessary modifications permitted by CMS (as described below) and then submit the SB to CMS for review.

2003 Summary of Benefits Changes:

Optional Supplemental Benefits- CMS has made certain changes to the Plan Benefit Package to display more detailed information concerning Optional Supplemental benefits on the Summary of Benefits for the following service categories: Chiropractic, Podiatrist, Transportation, Outpatient Drugs, Dental-Preventative, Dental-Comprehensive, Vision-Eye Exams, Vision-Eye Wear, Hearing-Hearing Exams, Hearing-Hearing Aids, and Point-of-Service. The Summary of Benefits report will display the premium and relevant sentences for these services categories if they are offered as Optional Supplemental Benefits.

In order to provide the information accurately in the PBP, the M+CO should enter Optional Supplemental benefits either in Section B or in Section D of the PBP. For further information please refer to 2003 renewal instructions which are posted on the website.

Note: For the optional supplemental benefit packages, sentences will not be generated for the cost sharing for Medicare-covered benefits.

New Lock-in Provisions-According to the Public Health Security and Bioterrorism Response Act of 2002, a Medicare+Choice eligible individual can may enroll or disenroll in a health plan through December 31, 2004. To reflect this change in the Summary of Benefits, please delete the following lock-in sentence from Section 1 of the Hardcopy SB:

"Starting January 1, 2002, you may be able to join or leave a plan only at certain times. Please call [Organization Marketing Name] or 1-800-MEDICARE (1-800-633-4227) for more information."

General Instructions

1. M+COs must adhere to the language and format of the standardized SB and are only permitted to make changes if approved by CMS. Changes in the language and format of the SB template will result in the disapproval or delayed approval of the SB.
2. The title "Summary of Benefits" must appear on the cover page of the document.
3. All three sections of the SB must be provided together as **one document** and may not be bound separately or placed in a folder in separate sections. M+COs may also describe several plans in the same SB package by displaying them in separate columns in the comparison matrix section of the SB.
4. Front and back cover pages are acceptable.

5. Printing font size of 12 point or larger must be used for the SB (including footnotes). Note: since Sections 1 and 2 will not be generated from the PBP in 12-point font, the M+CO should change the font to ensure that the font size is 12 point. M+COs may enlarge the font size and also use bold or capitalized text to aid in readability, provided that these changes do not steer beneficiaries to, or away from any benefit items or interfere with the legibility of the document.
6. Colors and shading techniques, while permitted, must not direct a beneficiary to or away from any benefit items and must not interfere with the legibility of the document. There is no requirement regarding the type of paper used.
7. It is acceptable to print the SB in either portrait or landscape page format.
8. It is acceptable for M+COs with multiple plans (separate ACRPs) to include more than one plan in the benefit comparison matrix (section 2). However, since the PBP will only print Section 1 and 2 reports for one plan, the M+COs will have to create a side-by-side comparison matrix for two (or more) plans by manually combining the information into a chart format.
9. It is acceptable for M+COs to display more than one plan together in the same columns of the benefit comparison matrix, provided all of the benefits are the same and only the service areas are different. Plans may identify the service areas at the top of the plan column of Section 2. Note: if anything beyond the service area is different, the plans must be displayed separately.
10 If the SB includes only one of several plans offered, the availability of other plans must be noted in the Annual Notice of Change (ANOC) letter. If the M+CO lists more than one plan offering, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB. Note: a model ANOC letter is provided in Renewal and Non-Renewal Instructions for Contract Year 2003, also available on CMS' web site.
11. If an M+CO wants to include mandatory supplemental benefits beyond those benefits found in the benefit comparison matrix, the M+CO must place the information in Section 3 of the SB. The M+CO must include a brief description of the benefits and any associated premium/copay requirements.
12. If an M+CO includes additional information about covered benefits in Section 3, the M+CO may include a page reference to this information in the appropriate box in the benefit comparison matrix using the following sentence: *See page___for additional information about (Enter the benefit category exactly as it appears in the left column)*

13. M+COs may include additional information about covered benefits in a separate flyer or other material and mail this with the standardized SB and the Annual Notice of Change Letter.
14. Enrollees whose source of enrollment is through an employer-sponsored group are not currently included in the mandated use of the standardized SB for either annual notification or initial marketing purposes.
15. CMS' policy regarding Value-Added Items and Services(VAIS) is described in detail in the Medicare Managed Care Manual section 60.1.2, which is also available on CMS' website. Briefly, CMS' policy with respect to marketing VAIS is as follows. M+COs can market, either through oral presentations or written materials and VAIS. VAIS may not appear in the Plan Benefit Package

(PBP) or the SB. However, organizations will be permitted to reference their pharmacy discount program in Section 3 of their SB, provided they also include the disclaimers listed below. In addition, if the pharmacy discount program is referenced in the SB it must clearly state (in the location that the pharmacy discount program is described) that the program will be available for the entire contract year. Organizations may include VAIS along with their Annual Notice of Change (ANOC) and SB in a one bound brochure as long as the VAIS is distinct from the ANOC and SB.

1. The products and services described on this page are neither offered nor guaranteed under the M+C organization's contract with the Medicare program, but are made available to all enrollees who are members of [Name of M+C organization].

2. These products and services are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the [Name of M+C organization] grievance process.

3. If you have any questions or concerns about these products or services, please call [Name of M+C organization] for assistance at [M+C organization customer service number]. Our customer service hours are [Enter hours].

Note: *HHS is presently working on marketing requirements for Value-Added Services under the Final Privacy Rule. Additional information will be disclosed once it becomes available.*

Section 1- Beneficiary Information Section

1. This section is to be incorporated into your SB exactly as it is generated by the PBP. Note: M+COs have the option of indicating at the top of this section a geographic name, for example, "Southern Florida." If used, the geographic name must match the geographic label indicated in the Health Plan Management System (HPMS).
2. Section 1, as generated by the PBP, will include the applicable H number and plan number at the top of the document. M+COs must delete this information.
3. The fourth paragraph (How can I compare my options?) contains a sentence "We also offer additional benefits, which may change from year to year." If this is not applicable to your plan, you must remove this sentence.
4. The second question and answer in Section 1 includes the plan's service area; the PBP will generate a list of counties, with an * indicating those counties that are partial counties. The M+CO may list the zip codes of these counties in this section or provide a cross-reference in Section 3 and list the zip codes here. The M+CO must also explain in Section 1 that the * indicates a partial county.
5. The second question and answer in Section 1 lists the plan's service area, but does not indicate that the information listed represents counties. Therefore, the M+CO must amend the SB so that the answer reads, "The service area for this plan includes the following counties: [list of counties automatically generated by the PBP].
6. The last sentence in Section 1 on page 2 states, "If you have special needs, this document may be available in other formats." M+COs contracting with CMS are

obligated to follow the regulatory requirements of the American with Disabilities Act and the Civil Rights Act of 1964. Compliance with these requirements satisfies the intent of the above referenced SB sentence. No additional requirements are imposed by the above referenced SB sentence.

Section 2 - Benefit Comparison Matrix

The SB benefit comparison matrix will be generated by the PBP in chart format with the required language. Therefore, the information included in the PBP must first be correct in order for the SB comparison matrix to be correct. M+COs should review the comparison matrix to ensure that all of the information presented is correct. Information presented in the benefit comparison matrix **must** match the information presented in the PBP, with the exception of the permitted and/or necessary changes discussed below. If any changes are required, the M+CO must make these changes in the PBP prior to the September 9th deadline for submission of the ACRP, generate a revised SB benefit comparison matrix, and include this matrix in its SB. CMS reviewers will have the benefit comparison matrix that is generated by the PBP and will compare this with the matrix provided as part of the plan's SB. Any discrepancies between the matrix generated by CMS and that provided by the plan (with the exception of those permitted below) will result in disapproval of the SB.

Footnotes

The comparison matrix generated by the PBP will not contain the required footnotes. Therefore, the M+CO must include the following footnotes provided below. Please note that the footnote number must appear in the text of the column and the footnote must appear at the bottom of each page. Note: For review purposes, the M+CO can list all of the footnotes at the end of Section 2, but the final proof copy must include the footnotes at the appropriate points in the text. If the M+CO chooses this option, the M+CO must notify the CMS Regional Office conducting the review and must indicate in the SB where the footnotes will actually appear in the final printed version.

(1) Each year, you pay a total of one $100 deductible.

This footnote must be referenced after every statement in the Original Medicare (OM) column that describes the required Medicare coinsurance, e.g., "You pay 20% of Medicare approved amounts." Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column. This footnote must also appear at the bottom of each page that contains this statement. These statements are contained in the OM column describing the following benefits:

- Doctor Office Visits
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Outpatient Surgery (both statements must be footnoted)
- Emergency Care (both statements must be footnoted)
- Urgently Needed Care

- Ambulance Services
- Durable Medical Equipment
- Prosthetic Devices and Medical Supplies
- Diagnostic Tests, X-Rays, and Lab Services
- Radiation Therapy
- Chiropractic Services
- Podiatry Services
- Outpatient Rehabilitation Services
- Bone Mass Measurement
- Colorectal Screening Exams
- Diabetes Self-Monitoring Training and Supplies
- Hepatitis B Vaccine
- Vision Services (only the second statement)
- Hearing Services (only for the statement regarding diagnostic hearing exams).

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

This footnote must be referenced after every statement in the OM column that describes the following benefits and after footnote (1), where applicable. The text of this footnote must appear at the bottom of each page that contains this statement. These statements are contained in the OM column describing the following benefits:

- Doctor Office Visits
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Outpatient Surgery (both statements must be footnoted)
- Emergency Care (both statements must be footnoted)
- Urgently Needed Care
- Diagnostic Tests, X-Rays, and Lab Services (both statements must be footnoted)
- Radiation Therapy
- Chiropractic Services (Manual Manipulation of the Spine)
- Podiatry Services (Medically Necessary Foot Care)
- Outpatient Rehabilitation Services
- Mammograms/Pelvic Exams
- Bone Mass Measurement
- Colorectal Screening Exams
- Prostate Cancer Screening Exams
- Diabetes Self-Monitoring, Training and Supplies
- Vision Services (only the first statement)
- Hearing Services (only for the statement regarding diagnostic hearing exams).

(3) A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new

benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

This footnote must be referenced after the words "benefit period" in the OM column describing Inpatient Hospital Care and Skilled Nursing Facility and the text of this footnote must appear at the bottom of the page on which these benefits are described. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column.

(4) Lifetime reserve days can only be used once.

This footnote must be referenced after the statement, "Days 91-150: $338 each lifetime reserve days" in the OM column describing Inpatient Hospital Care. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column. The text of this footnote must appear at the bottom of the page on which these benefits are described.

Section 3 -Plan Specific Features

This section is limited to a maximum of four (4) pages of promotional text and graphics and is not standardized with regard to format or content. Section 3 is used by the M+CO to describe special features of the M+CO beyond information contained in Sections 1 and 2 of the SB. Section 3 may contain non-standardized language, graphics, pictures, maps, etc.

The 4-page limit means that the information is limited to 4 single-sided pages or 2 double-sided pages. There are **no** exceptions to this limitation.

M+COs may use this section to further describe mandatory and optional supplemental benefits that appear in the benefit comparison matrix. If an M+CO chooses to do this, they may reference the information in the relevant section of the benefit comparison matrix using the following sentence: See page___ for additional information about (Enter the benefit category exactly as it appears in the left column.)

Permitted Changes To SB Language and Format

M+COs are only permitted to make changes to the benefit matrix or Hard Copy Summary of Benefits on a limited basis, which must be approved by CMS. Please reference the Renewal and Nonrenewal Instructions for CY2003 for further detail.

Closing Note:

The standardized SB is designed to provide the M+CO plan with adequate descriptive information to perform marketing of the M+CO's plans while at the same time assisting potential Medicare beneficiaries in performing comparison shopping for the health care provider best suited to meet their needs. The standardized SB will also be used to inform existing M+CO members of the benefit changes for the new contract year. Should you require assistance in clarification or use of this document, please contact your CMS Regional Office Plan Manager. You may also post your questions through the Internet

by emails to: sb2003@cms.hhs.gov. The SB Questions and Answers will be updated regularly and posted on the Internet at: www.cms.hhs.gov/medicare/acrp.htm.